Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Hope House

on 04/06/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory:83.33%
Percent of indicators rated Limited:16.67%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:88.00%
Percent of indicators rated Limited:12.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Keith Carr, Lead Reviewer, Forefront LLC/FNYFS

Tiffany Martin, Project Manager, Florida Network of Youth and Family Services

Pam Purnell, Residential Supervisor, CDS Family and Behavioral Health

Brooke Brown, Family Counselor, Anchorage Children's Home of Bay County

Chiquita Williams-Fountain, Operations Review Specialist, Florida Department of Juvenile Justice

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

1 Case Managers
2 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
3 Program Supervisors
8 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [ ] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [x] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [x] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [x] Visitation Logs
- [x] Youth Handbook

3 Health Records
0 MH/SA Records
5 Personnel Records
7 Training Records/CORE
17 Youth Records (Closed)
10 Youth Records (Open)
1 Other

Surveys

3 Youth | 3 Direct Care Staff | 3 Other

Observations During Review

- [x] Intake
- [x] Program Activities
- [x] Recreation
- [x] Searches
- [ ] Security Video Tapes
- [x] Medical Clinic
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [x] Discharge
- [x] Treatment Team Meetings
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [x] Meals
- [x] Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.
Rating Narrative

Cases or samples of Probation Respite and Domestic Violence referrals were not available for this on-site program review.

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida Northwest (LSF-NW) is a non-profit, human services agency dedicated to helping all youth and families in the Western Region of North Florida. The administrative offices of LSF-NW are located in Crestview, Florida. The agency has various programs located in the 1st Judicial Circuit. The LSF agency is accredited by the Council on Accreditation (COA).

The LSF-NW agency provides Residential and Non-residential CINS/FINS services for Walton, Okaloosa and Santa Rosa Counties. The Hope House Emergency Youth Shelter is the residential program located in Crestview, Florida. The Non-Residential program has counselors that provide counseling services to client in the aforementioned counties. Counselors are assigned to cover specific geographic service regions. There is also a south non-residential office in Fort Walton Beach.

The LSF-NW agency participates in national programs including the National Safe Place Program. In addition to the collaboration with Safe Place sites, the program also has a vast number of local interagency agreements with the surrounding communities, such as the DJJ Council, schools, businesses, and various community-based organizations in an effort to make agencies and local area families aware of available CINS/FINS services.

Standard 1: Management Accountability

Overview

Narrative

LSF Northwest operates both the HOPE and Currie House Shelters (residential) and Non-Residential CINS/FINS Program located in Escambia, Santa Rosa, Okaloosa, and Walton County, Florida and is also the designated CINS/FINS provider for both Escambia, Okaloosa, and Santa Rosa Counties.

The program has a management team that is comprised of the following positions: North Region Director; Clinical Director that is a licensed Mental Health Counselor; Residential and Non-Residential Counselors; a Residential Services Manager; Residential Direct Care Staff, Outreach Coordinator; Administrative and Maintenance staff. At the time of the QI visit, the following positions were vacant: 2 full-time Residential Youth Care Specialist and 2 Residential part-time Youth Care Specialists positions.

The Regional Director and Shelter Manager oversee the operations and duties at two shelters in Pensacola and Crestview, providing oversight and supervision of the direct care workers that are responsible for the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Northwest Region.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires.

LSF Northwest maintains multiple outside partnerships with the agency to provide various community agencies that ensure a continuum of services for its youth and families. The program has a highly active local food outreach program. In addition, the program has a regional outreach component across the service area. These programs involve participation from staff and system partners to focus their outreach activities in designated high crime zip codes and low performing schools.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are a total of sixteen (16) staff members employed with the Okaloosa/Walton Counties Lutheran Services Hope House. A sample of five staff files were reviewed and one volunteer file. Of the five staff files reviewed, all had background screenings completed prior to being hired. The one volunteer file did not have the date that the volunteer actually started. It was later determined after speaking with staff that the volunteer was a local school board employee; however, the program never received physical evidence of the background clearance. The volunteer has since been cleared and rated eligible by the Department's Background Screening Unit (BSU). Currently, all staff and volunteer have been cleared through the Department's (BSU). All of the applicable employees were rescreened within the five years of employment. This was also verified on the Department's BSU system by this reviewer. All files also contained the hard copies of the verifications. The program has an updated copy of their Annual Affidavit of Compliance of Good Moral Character for Level 2 Screening Standards signed by the Director, Beth Deck, and notarized on January 4th, 2016.

One volunteer was not cleared through background screening prior to volunteering with youth at the program. Reportedly, when he started volunteering, he was employed with the local school board. According to staff, he has never been alone with any youth and he volunteers less than ten hours per week. The volunteer has since been cleared and rated eligible by the Department's Background Screening Unit as of October 13, 2015.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program staff has provisions in place which addresses the safety and security and provides for an abuse-free environment. Each employee has a Code of Conduct that is discussed and signed when hired by the agency. A physical copy is also signed and placed in the staff records. The program has the Abuse Hotline and Central Communications Center (CCC) numbers posted where it is visible and accessible within the facility. This was observed during the facility tour. The flyers were observed to be posted in the day room and in two youth service specialist offices. The program also has the numbers listed and the nature of the numbers explained in the youth handbook as well. The program has a grievance procedure that allows youth to report any complaints in written detail and explain what solution would be considered appropriate by the youth. There is also a place on the grievance forms that provides a summary of the action taken which is signed by the youth and their counselor or youth counselor specialist. The youth has the option of submitting the grievance directly to staff and/or by placing the form in a locked box.

The program has two documented grievances filed within the past six months. Both forms had an action step narrative completed and signed by the youth and a staff member.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The facility has the Department of Juvenile Justice (DJJ) CCC contact telephone number and the Department of Children and Family (DCF) Abuse Hotline numbers visibly posted and accessible for the youth and staff. There was a total of ten incidents reported to the CCC within the past six months. The CCC's are reported in two places at the facility—in the facility's daily record logbook as well as in a CCC log book; however, there is no consistency with the CCC's being reported in both of the books simultaneously.

Of the ten incident reports, only one was noted to not be reported within the two hour time-frame. It was a missing key report. It was explained in the incident report that the key was found within thirty minutes; however, three days later it was discovered that a key was missing from the key ring.

On the last day of the review, it was brought to the review team's attention via email that a CCC alert was posted regarding the program. The incident occurred on April 6, 2016. It was reported on April 7, 2016. The CCC was flagged as being reported late; however, this was not brought to the review team's attention by the program's staff.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has policies and procedures regarding staff training which include a listing of required training topics as well as specified training needed for supervisory staff. Staff training files are well organized and include detailed training transcripts and copies of corresponding certificates for some trainings.

Three (3) first year training files were reviewed. Of the three, each individual received at least 115 training hours within their first year of employment.

Four (4) files were reviewed for annual training requirements. Of those files, three (3) have already met the minimal 40 hour requirement. The remaining staff has 38 of the 40 hours and has approximately 6 months to obtain the

hours. Training hours for both first year staff and others were provided by agency in-house trainers, online resources and other local agencies.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure for analyzing and reporting information within the agency. Agency collects information on a monthly basis on the following: grievance, client satisfaction, client functioning, outcome data safety and staff turnover utilizing LSF Statewide Google Sheets reporting function. Meeting minutes were reviewed from monthly meetings. There is evidence of recommended program changes and improvements as it pertains to occurrences across programs within previous months. However, minutes did not clearly reflect recommendations based on four key areas listed in the agencies procedure.

Staff reports the process for review and reporting of data by Quality Improvement Teams that has evolved over time but is not clearly reflected in monthly discussions. Agency is currently not completing reports on medication via Pyxis reporting function or Knowledge Portal.

Exception: Agency is currently not completing reports on medication via Pyxis reporting function or Knowledge Portal.

Recommendation: Clarify current process for reporting, reviewing and making recommendations for improved practices. Implement system that would capture recommended changes and their impacts on agencies functioning.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Agency has written policy and procedures for client transportation. There are two vans on site: 2008 Dodge, 8 passenger and 2005 Ford, 15 passenger. Agency reports the 15 passenger van has had mechanical issues. March 28, 2016 van's engine was serviced and there have been no reported issues since that time. Agency policy reflects what should occur in the event only one staff is available to transport a youth and documentation of approval from Shelter Manager. Agency maintains a separate log with this information. Procedures also outline seating arrangements for staff depending on the number of clients in the van. Van logs are consistent with agency policy regarding supervision and staff to youth ratio. Van log includes date, destination, time departed and arrives, mileage, and driver initials and comments section.

There is an exception documented for this indicator. The agency is not documenting instances when it has approved single client transportation. The agency must document when it has notified a designated supervisor and that person acknowledges and approves a single driver and single client transportation situation.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has a policy and procedures written for outreach and interagency agreements. Currently, the Hope House participates in feeding the community through an outreach program facilitated by one LSF staff and volunteers. Agency is also an active participant in the Safe Place program and has relationships with approximately 80

businesses within the service area and holds approximately 15 interagency agreements. Agency CEO reports DJJ Council Meetings have not been facilitated in all counties they service but reports Board meetings are held quarterly.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services of Florida Hope House (HH) Residential and Non-Residential Counseling Program provide CINS/FINS counseling services for youth and their families in Walton, Escambia, Santa Rosa, and Okaloosa Counties in Florida. The program continues to maintain working partnerships with local service organizations. Hope House provides individual, group and family counseling services. The program offers an experienced Licensed Clinical Director and 3 other residential and non-residential counseling staff members who all have master level degrees. The HH program receives referrals from local schools, the Department of Juvenile Justice, and the Department of Children and Families as well as the local courts. HH also maintains office space at various community sites in the Florida Panhandle area.

The LSF-NW agency provides residential and non-residential services to youth 6-17 years old. The Youth Shelter residential facility is located in Crestview, Florida. The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The agency LMHC supervises the counseling team comprised of nine (9) Counselors that service clients in both Pensacola and Crestview, Florida service areas. The Non-Residential program services client service needs across several counties. Several of these counties are in rural and outer-lying areas. The agency provides several services. The referrals for services are received from parents, schools, counselors, the court system, the youth themselves and other sources. The services provided by LSF-NW include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home/community. Youth also receive referrals for substance abuse and mental health services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has comprehensive policies and procedures addressing the elements of the indicators such as 24 hour access, timeframes for screening and other related areas. This reviewer evaluated 4 residential files (2 open and 2 closed) and 4 non-residential files (2 open and 2 closed). All 8 of the files met the elements of the indicator. One of the files did not contain the receipt of services page indicating that the parent/guardian received the rights and responsibilities, CINS/FINS brochure and grievance procedure. The reviewer interviewed a youth care staff and she showed the reviewer the documentation in a separate medication folder; she explained that the forms were moved from the shelter file into the medication file once the client is active in shelter.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Psychosocial Assessment indicator. This reviewer evaluated 4 residential files (2 open and 2 closed) and 4 non-residential files (2 open and 2 closed). Three (3) of the files (all non-residential) contained updated psychosocial assessments due to the original assessment being less than 90 days old. The other 5 files (1 non-residential and 4 residential) all contained psychosocial assessments that were completed either the day the client was admitted into shelter or the day after. All 8 of the psychosocial assessments and updated psychosocial assessments were completed within 1 day which is beyond the 2 to 3 session timeframe and were all signed by a master level counselor and supervisor. There were no elevated risks indicated in any of the files.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a policy and procedure addressing the elements of the case/service plan. It indicates that the service plan is completed within 7 working days of completing the psychosocial assessment and addresses information that is included in the service plan. The policy states that in non-residential cases the service plan is initiated at the first intake session.

This reviewer evaluated 4 residential files (2 open and 2 closed) and 4 non-residential files (2 open and 2 closed). All 8 of the files contained service plans that were developed within 7 days of the psychosocial; in fact all of the case plans were developed the day of the intake which exceeds the requirement. All case plans were individualized to meet the needs of the client. In 2 files, completion dates were not documented, however this is due to the client being new to the shelter. In 3 files, 30 day progress was not indicated due to services not being in place for the appropriate amount of time. All files contained signatures of the client, parent/guardian and supervisor. All of the case plans were also dated to document the date the plan was initiated.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Case Management and Service Delivery. This reviewer evaluated 4 residential files (2 open and 2 closed) and 4 non-residential files (2 open and 2 closed). Of the 8 cases, 2 non-residential cases had documentation to indicate the client's assigned counselor. Five (5) of the eight (8) cases indicated a need for additional services; referrals were made to ensure that those needs were met. All 8 files documented support for families and service plan initiation. There were no referrals to the case staffing committee needed nor was there a need for monitoring of out-of-home placements.

The agency policy states that each client will be assigned a counselor. Six (6) files did not contain documentation of an assigned counselor. Reviewer interviewed the clinical director and it was reported that the counselors are given cases based on their location and since there is one counselor per area the assignment is not documented in writing. (Recommendation to align agency policy and procedures with standard requirements to prevent issues with practice not meeting policy and procedure).

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Counseling Services indicator. This reviewer evaluated 4 residential files (2 open and 2 closed) and 4 non-residential files (2 open and 2 closed). The residential and non-residential files had documentation supporting that counseling services are in accordance with the case/service plan. In all 8 files the client's presenting problems are addressed in the psychosocial assessment, service plan and service plan reviews. There is evidence of ongoing clinical review as well.

There is limited case notes documenting all of the services provided to the clients in all 8 files. In 2 files, there were gaps of time unaccounted for. In 1 file there was a 14-day time span with no documentation and in the other file 9 days unaccounted for. The non-residential counselor and clinical director were interviewed. The counselor reported that for one of the weeks where no activity is indicated she forgot to document a note and for the other

week she was out of the office. The clinical director reported that documentation for counselor absence is not required by their agency to be documented in the case notes. In all 8 files the case notes did not correspond with the contact log. Also the contact log did not specify in detail what transpired in the event. Reviewer interviewed clinical director; she reported that if contact is documented in contact log then the agency does not require the counselor to document the detailed event in the case notes. All 4 residential files did not have documentation of group counseling 5 days/week. Reviewer interviewed the residential counselor who reported that recently it has been staffed to have an additional counselor assist in group counseling. The residential counselor is the only counselor conducting groups at this time. All of the group counseling notes are kept in a separate folder by the residential counselor.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure that addresses the elements of the Adjudication/Petition Process. Reviewer interviewed the clinical director and she reported that there haven't been any petitions filed in the last year.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has a policy and procedure for maintaining confidential youth records. All files are kept in a locked file room and inside locked file cabinets accessible to staff only. Youth records are neatly organized by numbers (utilized to identify clients) and color (used to differentiate funding/referral source). CINS client files are marked confidential on front and back.

Agency has a locked, opaque container that is marked confidential and is used to transport client files. HOPE House Residential and Non-Residential files are typically not transported for any reason.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hope House Shelter is licensed by the Department of Children and Families (DCF) as an eight (8) bed Child Caring Agency effective through September 27, 2016.

The Hope House residential shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program. The shelter also serves youth referred from the Department of Children and Families DCF. The Hope House youth shelter is capable of serving Special Populations youth including Staff Secure, Domestic Violence, Probation Respite and Human Minor Sex Trafficking populations.

The shelter program management team is comprised of a Residential YCS III Shelter Manager, one (1) YCS II and ten (10) YCS direct care staff members. Each shift also has YCS that is the designated team leader. An organizational chart dated 03/10/2016 shows a total of eleven (11) Youth Care Specialist positions in the shelter program. There are also two (2) residential counseling positions.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Health and medication-related activities are the responsibility of the staff.

The facility has not been able to hire a part-time Registered Nurse (RN) as required by the 2015 CINS/FINS contract. The agency has struggled with consistently maintaining male staff members across all work shifts. They are working to hire more male staff, as well as the Registered Nurse. The agency has advertised available positions on LSFNET.ORG, Employflorida.com and occasionally on weartv.com and monster.com. Oversight of clinical mental health services is provided by the agency's Licensed Mental Health Clinician.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter is an eight bed facility located in Crestview, Florida. The interior of the facility is clean and in good repair with ample lighting and have posted maps/required postings including their current DCF license throughout the building. Moreover, the shelter has a nice home-like feeling. The youth's living areas are neat with nice bedding and are free from contraband. The program provides structured daily activities and the program schedule is posted and accessible to both staff and youth. There is a designated box for grievances however it isn't labeled. A current Disaster Plan is located throughout the shelter in four places for easy access in the event of an emergency. The menus are posted in the kitchen and have been approved by a licensed Dietician. The Department of Health Inspection was conducted in June 2015 and was rated Satisfactory. The fire inspection was conducted by the North Okaloosa County Fire Department on September 17, 2015 and was rated satisfactory and the facility fire extinguishers were inspected in August 2015.

The exterior of the facility is well maintained with nicely landscaped grounds free from debris and hazardous terrain. In addition, all outside lighting was functional and well-positioned. The agency has ample recreation space and open green areas for large muscle activity and exercises. The agency also has an active vegetable garden that is maintained by staff and youth. The outside area also includes a basketball hoop and an open court area for court games. Agency and staff vehicles were locked and the agency vehicles had the required first aid supplies, as well as a fire extinguisher, flashlight, insurance cards and the knife for life.

At the time of the review, it was reported that the cameras were recording but staff was unable to access the system to review footage. Technical Assistance was notified however the problem will not potentially be resolved

until Friday.

All chemicals in the facility are securely stored and there is an MSDS sheet on each chemical used at the facility which is maintained in a three ring binder; however, there isn't consistent inventory of the chemicals.

The building is secure and there is a system in place to control keys. However, on 3/6/16 there was an incident where a youth was able to take possession of the house keys. Additionally, though the keys were retrieved on 3/6/16, it wasn't discovered until 3/8/16 during contraband search that a key had been removed from the ring while in possession of the youth until he turned it into staff.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program orientation is initiated upon intake and completed within 24 hours of initial entry.

Youth are given a tour of the facility and are given the opportunity to ask questions while staff reviews agency procedures. During orientation youth are informed of their rights, program rules, the grievance process and access to the Florida Abuse Hotline. Procedures to access medical/dental services and mental health care/substance abuse services are discussed with the youth as well as the Visitation policy, Telephone Policy, Dress Code, Program Goals and services offered. Youth are provided with an Orientation Handbook outlining all information discussed during orientation and acknowledgment of such is captured via signature on their inventory sheet. Parent signatures were obtained acknowledging receipt of the Orientation Packet as well in the Log Book.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a process in place upon intake that considers potential safety and security concerns of the youth through an initial classification system for the purpose of assisting staff with room assignments. This system looks at many dynamics including but not limited to gender, age, history and physical size/strength. If it has been determined by staff that the youth has risk factors such as security or suicide factors based on the information gathered, an alert system is immediately initiated.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure that addresses the elements of the logbook process. Logbook data dating back the last 6 months were reviewed. All of the elements of the indicator were met. The safety and security issues are documented using a color coded system. The color blue indicates intakes, discharges and transfers; green are parent notifications; pink is used for important information and late entries; yellow is used for very important information and the color orange is used for staff logging in and out of shifts. Incidents, medical alerts and fire drills also have certain colors for identification. All entries are legible and clearly documented with date, time and signatures. Shift changes, recording errors, and supervision are all accurately documented. All entries are made with ink without the usage of white out or erased areas.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written behavior management system (BMS) in place known as Motivation System that is explained during orientation. There are three levels in this system that includes Assessment, Daily and Achievement components. The current process involves residents remaining on the assessment level for a total of two to three days. After completion of the initial assessment period and their adjustment to the program rules the youth are placed on Daily. During this phase of the system, the youth work on identified behavioral target goals to work towards achievement. Residents can move up to the achievement level where they can earn additional privileges once they have worked off their system standing points which is based on their length of stay. On Achievement level, residents are still responsible for completing their target skills but no longer carry a point sheet. The Behavior Management System is designed to gain compliance from the youth and has a wide variety of incentives and rewards to motivate the youth to excel in the program. Residential Supervisor Lee Bandy is the primary trainer of the staff and supervises the implementation of the system and evaluates the staff based on supervision.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Agency has a policy and procedures outlined for staffing and youth supervision. Staff schedule is posted in staff office area and contains dates for two week intervals. Scheduling patterns are as such that agency is in compliance with staff/youth ratio. Staff are completing bed checks in 10-minute intervals. Bed check dates/times reviewed: 4/2/2016 12:00am-3:00am, 4/3/2016 4:00am-6:00am, 4/4/2016 10:00pm-11:00pm. Currently, the agency has 8 female staff and 4 male staff. One (1) of the four (4) male staff will no longer be working at agency effective April 7, 2016. Agency has reported they do not receive a high number of applications from males. Of those received only a small portion are eligible for hire due to lack of experience or not passing background screening. Shortage of male staff impacts the agency's ability to ensure at least one male is on shift at a time. Approximately, one third of shifts do not have male coverage.

At the time of the review, agency was not able to access camera footage. From Monday, March 7, 2016 to Friday, April 1, 2016 agency had new floors installed. During floor installation, cameras were unplugged to complete the work. On Friday, April 1, 2016, YCS III noticed cameras were not functioning properly and called Security Engineering to request service. Company will come to agency on April 8, 2016 to service cameras.

The agency reported that they are not certain when the camera surveillance system stopped recording. The agency did inform the review team that they have requested a work order to diagnose and repair the system. A copy of the request for a work order was provided to the review team on day 2 of this on-site program review.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has a policy and procedure for providing services to Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite and Probation Respite youth. Within the past year HOPE House has not served any Probation Respite, Domestic Minor Sex Trafficking or Staff Secure Youth. Currently agency has not established referral process for youth on probation with local probation officers, however has stated agency has an overall good working relationship with probation department. At the time of the review, the agency had one Domestic Minor Sex Trafficking victim but has not utilized this classification under the Special Population category. Because the current youth has not posed risk to other residents or herself while at HOPE House there has not been a need for additional supervision. Five (5) client files were reviewed. Of those, one did not include any information supporting

evidence that the youth was officially charged with a DV crime and has been assessed at the JAC. The same file was additionally missing information that reflected services provided to youth focusing on aggression management, family coping skills or other intervention designed to reduce reoccurrence of violence in the home.

One (1) file did not include any information supporting evidence that the youth was officially charged with a DV crime and has been assessed at the JAC. The same file was additionally missing information that reflected services provided to youth focusing on aggression management, family coping skills or other intervention designed to reduce reoccurrence of violence in the home.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process, residents are placed on the appropriate supervision level or referred out to other local mental health facilities as needed. Depending on the risk identified, the residents are placed on the applicable alert status. The agency ensures that measures are taken to maintain a safe and secure placement and supervision are provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate and conduct emergency drills on a routine basis. The agency's staff receives orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training, CPR and First Aid. In addition, the agency does have a certified Managing Aggressive Behavior (MAB) Trainer in the organization.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy in use at this site is the same across all four (4) residential LSF shelters. The agency has a detailed policy on Healthcare Admission Screening. A sample of nine (9) client files were randomly selected to assess the agency's practice and adherence to the requirements of the Healthcare Admission Screening indicator. A review of the agency's current policy was conducted on-site and the current policy was found to have met general requirements for the agency's staff to conduct healthcare screenings on all clients admitted to any of its program.

The agency has two (2) health screening methods. The agency uses the 2 page CINS/FINS Intake Form as an initial screening form. The CINS/FINS intake section contains a health screening section where the agency screens observable injuries, dental or health concerns; recent hospitalization for medical conditions/concerns, recent treatment for medication for a mental health disorder; currently taking any medication; allergies; dietary restrictions, nutritional concerns or fitness issues. The CINS/FINS Intake form also screens for 24 other potential health issues. The CINS/FINS intake form also captures health insurance.

The agency also uses a five (5) page LSF health screening form as the primary health screening instrument used by all LSF agencies. The 5 page Shelter Intake form contains general demographic screenings questions; eligibility for CINS; emergency procedures; health screening; family assessment; basic needs assessment; and financial history.

Agency provided a total of nine (9) clients that meet the requirements to be placed on Suicide Risk supervision level. A review of eight (8) randomly selected files from the client roster for the last 6 months were reviewed to determine the accuracy and completeness of all health admission screenings. Of these files, all contained both the 2 page and the 5 page health screening forms. In addition, all sections in each client file reviewed had evidence that each health admission screening section in each form was fully completed as required. All the sections contained documentation of a signature of the staff person completing the health admission screening form. At the time of this on-site program review, the agency has not secured a part-time nurse. The agency is actively

advertising and recruiting a qualified person to fill this current vacant position.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has four (4) CINS/FINS shelter sites. The policy in use at this site is the same across all 4 LSF Shelter shelters. The agency has a detailed up-to-date policy and procedure for the Suicide Prevention screening, assessment and supervision practice in this area. A review of the agency's current policy was conducted on-site and the current policy was found to have met general requirements. The agency's policy requires that all residents and non-residential clients admitted be screened for suicide risks. The current practice for screening for suicide requires that the agency use the CINS/FINS Intake form and the Evaluation of Imminent Danger Survey (EIDS) to determine the past and present risk for suicide. The CINS intake form screens each program participant for suicidal risk by asking each individual the six (6) suicide risk questions consistent with the FNYFS policy and procedure manual. The EIDS is also used during intake and a resident that meets a score of 5 or more is placed on suicide risk observation status. The agency has two (2) levels of suicide risk supervision that include Sight and Sound and Elevated Supervision. At the time of this review, the agency's current plan for addressing suicide risks addresses all requirements of the 4.02 Suicide Assessment QI indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A total of six (6) files residential client files were reviewed on site. Each client file reviewed contained evidence that each was screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. All residents are initially screened by a Direct Care Worker. The documentation of each resident resulted in a positive rating for the presence of suicide risk. In all 6 case files reviewed, the program immediately placed the resident on the designated supervision level. In addition, a qualified Residential Counselor was also contacted to verify the placement of the youth on supervision. Each client file reviewed in this sample had documentation of observation check logs and official assessments completed by non-licensed staff being overseen by a licensed clinician on staff. A review of observation logs indicate that observation checks were completed and documented as required. The Observation documentation was reviewed to include precautionary observation logs and less than thirty (30) minute checks. Specifically, Documentation of clients being placed on sight and sound status and taking youth off sight and sound status are documented as required in 6 out of 6 clients files reviewed.

At time of this on site review, the agency has one (1) residential counselor that has been employed with the agency for six (6) months. The agency is working toward finalizing training process to confirm that the non-licensed Residential Counselor has completed a minimum of 5 Suicide Risk Assessments with the agency's Licensed Mental Health Counselor Staff.

No exceptions were noted for this indicator.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy on medication. The policy was last updated on October 1, 2015. The agency YCS III/Residential Supervisor provided access to the agency medication storage and distribution practice. The agency has a CareFusion Pyxis MedStation 4000 automated medication dispensing machine. The agency has been using the machine since late September 2015. The agency has a total of 10 Users. Of these Users, three (3) are Super Users. At the time of this on-site review, the MedStation houses all controlled medications, non-controlled medication and over-the-counter medications. The Shelter Residential Supervisor did conduct a mock inventory for the reviewer. During this on-site review of agency practice, the reviewer observed multiple discrepancies.

Agency storage practices were reviewed on site. The agency has all medications stored in the Pyxis MedStation.

All medication is controlled and non-controlled medications are stored in separate, locked cubies in drawers 2-5. All over-the-counter medications are stored in the top drawer of the Pyxis MedStation.

Agency does conduct shift-to-shift counts on controlled medication. The agency conducts medication counts for non-controlled and over-the-counter medication once per week.

The agency does have a bio-hazard waste bin. The agency does conduct drug verification. Agency Low Dose notice practice is supposed to occur once a client's medication level reaches a 7 day supply.

The agency medication disposal process requires that the agency contact parents/guardians and inform of any medications left after discharge. The agency secures the medication and contacts the parent/guardian requesting that they pick up the medication up to 90 days. After 90 days, the agency disposes the medications. If the medication is a controlled medication the agency contacts the Police Department to pick the medication up to be disposed. If a non-controlled medication requires disposal, the agency uses 2 staff members to crush the medication and combine them with coffee grinds/water and then disposes the waste in the trash.

The agency sharp inventory is required and is generally conducted on weekly basis. Some counts were not found to be conducted weekly.

The agency does not have a Registered Nurse employed on a part-time basis.

The agency has a total of 171 discrepancies logged in the Pyxis MedStation Discrepancy Audit Report. Of these, only five (5) have been resolved by the agency. Evidence of a process to identify the root cause of discrepancies/errors when distributing medications is not in place at the time of this on-site review.

The agency policy requires that the sharps housed in the shelter be counted a minimum of one time per week and when distributed to and collected from a client. Agency sharp inventory counts are inconsistent between February 2016-April 2016 for Jr Acetaminophen and Triple Antibiotic Ointment.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure for the medical/mental health process. The program maintains an Alert Roster with all of the youth's alerts concerning youth's medical condition, physical activity restrictions, allergies, side effects of prescribed medications, and pertinent treatment information. During this review, there were six youth residents. Of the six youth residents, three of the youth had medication and/or allergy alerts. Three of the youth had no known allergies or medications. The alerts are updated daily or as needed. All of the youth are low risk and none are court ordered. None of the youth are currently on suicide precautions. This information is also discussed daily at shift change/shift pass down information. Review of the shift pass down sheet provides documentation that all of the areas regarding youth medical/mental health status is covered.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has an Emergency Mental Health and Substance Abuse Service Plan. The program's policy was reviewed at the youth shelter. The program maintains a binder/book at the shelter facility with all local emergency contact numbers as well as instructions for emergency procedures in the main youth care specialists office in the event of an emergency. The program also has monthly mock emergency drills with the staff for preparation in case of an emergency. Review of agency emergency exercise drills confirms that emergency mock drills are being

conducted on a monthly-quarterly basis. The program has a contracted registered nurse that provides training on an as needed basis to staff members in the delivery of medication. A list of the staff was reviewed and confirmation of the training was also verified.

In the past six (6) months there has only been two off-site youth transports for emergency medical care. This was reported to the Department's CCC and documentation of the parental/guardian contact and follow-up was made. Only one of the youth received a diagnosis and follow-up care. Youth was discharged from the facility for parent/guardian to provide follow-up care for three days and then youth was returned to the facility. Transport of both youth for emergency medical care was also recorded in the facility's daily logbook as well as the facility's incident report book.

The agency has all required emergency equipment including fire extinguishers, knife for life, wire cutters and stocked first aid kits. There are also fire extinguishers, seat belt cutters and window punchers and first aid kits in the transportation vehicles. At the time of this on-site review, all staff members are required to receive emergency training including fire safety, CPR, First Aid and Universal Precautions.